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## Improving Rural Mental Health Service Quality Through Partnerships and Innovation

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## **Improving Rural Mental Health Service Quality Through Partnerships and Innovation**

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### **Abstract**

In rural areas, poverty, geographic isolation, cultural differences, limited availability of providers, and other barriers can prevent the engagement and retention of clients. As a result, individuals living in rural areas often enter care later in the course of their illness with more serious symptoms, and require more intensive services. The Big Island Substance Abuse Council (BISAC) has attempted to reduce the effects of these barriers by implementing several innovative, agency-wide quality improvement efforts within a five-year span from 2012-2017: (a) a research partnership with a local university, (b) prioritization of leveraging information technology and electronic health records for a wide array of decision-making, (c) rebranding and grass roots marketing, (d) cultural competence in service delivery, and (e) routinized training and supervision. The methods by which these initiatives have developed within a rural behavioral health setting offer both suggestions and optimism for the proliferation of similar approaches elsewhere. This paper provides an account of BISAC's infrastructure and program improvements, and illuminates several thematic lessons learned across implementation efforts. As described here, such innovations might provide clues for utilizing data to help guide decision making, integrating cultural values, and monitoring operations within rural mental health settings.

Keywords: substance use treatment, community, program development, rural, program improvement, implementation

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## **1.0 Introduction**

### ***1.1 Context of Rural Mental Health Treatment Within Hawai‘i***

There remains a significant need for mental health services in rural America. According to the National Rural Mental Health Comorbidity Survey Replication, 54.2% of residents of rural areas develop a mental health disorder at some point in their lives, amounting to over 30 million people (McCall-Hosenfeld, Mukherjee, & Lehman, 2014). In rural areas, poverty, geographic isolation, concern about stigma, limited availability of providers, cultural differences, and other barriers often prevent the engagement and retention of clients (e.g., Brenes, Danhauer, Lyles, Hogan, & Miller, 2015; McCall-Hosenfeld et al., 2014; Pullmann, VanHooser, Hoffman, & Heflinger, 2010). For example, in a large survey of rural elderly adults with internalizing problems, the most common practical barrier to mental health services was cost—with the combined endorsement of distance and transportation barriers occurring at a similar rate—while the most common endorsed barrier overall was that respondents “should not need help” (Brenes et al., 2015, p. 1172). In an Australian study of rural residents with internalizing or substance use problems, approximately 80% or more endorsed concerns related to stigma—for example, negative judgments of others, belief that they should be able to solve their own problems, or that certain problems should not be discussed outside of family (Komiti, Judd, & Jackson, 2006). Regarding provider availability, a large American survey found that more than 85% of the nearly 1,700 geographical areas deemed by the federal government as underserved by mental health providers were rural (Bird, Dempsey, & Hartley, 2001). Specifically regarding Hawaiian cultural beliefs, two hypothesized barriers to engagement in treatment include an understanding of illness and healing that sometimes diverges from western norms, as well as a broad mistrust of western providers given the fraught historical relationship between White Americans and the Hawaiian people (Oliveira et al., 2006). As a result, if individuals living in these areas enter care at all, they often do so later in the course of their illness with more serious symptoms and require more intensive services. Multiple national studies have indicated that rural residents are less likely to receive mental health counseling or therapy services than their urban counterparts, despite experiencing more severe mental health concerns (e.g., suicide) at higher proportions compared to urban residents (Fontanella et al., 2015; Hauenstein et al., 2007; Ziller, Anderson, & Coburn, 2010).

The need for increased service access in the state of Hawai‘i is particularly pronounced, as the state’s geography creates numerous barriers for effective health care delivery. The eight major Hawaiian islands are separated by the Pacific Ocean, with the majority of the state’s population, physicians, hospitals, and other health resources residing on O‘ahu (Oliveira et al., 2006). Although O‘ahu has a larger number of residents who are uninsured, of low-income status, and/or immigrants, Hawai‘i island, or the Big Island, has a significantly higher percentage of underserved individuals, fewer resources, and greater access challenges (Belforte, Carter, Reinisch, & Zheng, 2013). As is common in rural communities, residents on Hawai‘i island have limited land access to services (Lambert & Hartley, 1998) and

assume costly transportation costs in order to receive specialty care (Oliveira et al., 2006). Native Hawaiian communities report high rates of substance abuse challenges and are also disproportionately represented in low access areas (Belforte et al., 2013).

The Big Island Substance Abuse Council (BISAC) was created in 1964 to provide substance use treatment in the context of these various challenges. BISAC was initially started to address the growing prevalence of alcoholism and provide a support group for individuals and families experiencing addiction. BISAC's mission is to provide culturally appropriate, evidence-based behavioral health care treatment for all of Hawai'i island via a comprehensive continuum of substance abuse treatment services, including outpatient and intensive outpatient treatment, three therapeutic living programs, two clean and sober housing programs, mental health services, employee assistance programs, a vocational training program, and a therapeutic garden. BISAC operates on an average annual budget of approximately \$4.5 million, and has three stand-alone sites on the Big Island, while also providing services to students in 32 public middle and high schools. BISAC maintains a permanent staff of approximately 60 employees, 25% of whom engage in administrative duties, 5% are clinical directors, and 70% are service providers—including clinical interns, case managers, counselors, and masters-and doctorate-level clinicians. Clinical services are provided face-to-face in a variety of group and individual formats, ranging in intensity from outpatient services to the aforementioned therapeutic living program. Of the 663 clients enrolled for services in fiscal year 2017, 68% were male and the average age was 35.3 ( $SD = 11.6$ ) years. In 2017, 48% of adult admissions reported a primary drug of choice as amphetamines, 26% reported alcohol, 15% cannabis, and 7% opioids.

## **2.0 Toward Improving Quality of Behavioral Health Care**

Within a five-year span from 2012–2017, BISAC invested in five organization-wide improvement intervention efforts to enhance the overall quality of care for all its patients: (a) a research partnership with a local university, (b) leveraging information technology and electronic health records for a wide array of decision-making, (c) rebranding and grass roots marketing, (d) cultural competence in service delivery, and (e) routinized training and supervision.

The purpose of this article is two-fold. First, we describe the historical evolution of BISAC's infrastructure and program improvement investments within the evolving behavioral health care delivery context. Second, we offer lessons learned from implementation of these improvements within a mid-size, rural substance abuse treatment organization undergoing a leadership transition. Both the evolution and endurance of these programs might provide suggestions and hope for the proliferation of similar approaches elsewhere.

### **2.1 Evolution of Improvement of Care Initiatives**

After eight years of stable leadership, BISAC transitioned to a new chief executive officer and several new board members in 2012. One of the first major aims of new leadership was to identify and address organizational needs—a process that was generally informed by principles defined in implementation outcome research—including acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability (Proctor et al., 2011), as they related to implementing quality improvement efforts (b), (c), (d), and (e) introduced

above. In an effort to achieve acceptability (i.e., satisfaction of providers and consumers related to improvement initiatives), over the course of a six-week period, the chief executive officer and the clinical lead conducted an informal needs assessment, interviewing all staff members individually about the challenges, strengths, and perceived vision of the organization. Leaders also conducted outreach meetings with community stakeholders and administered surveys to adult and adolescent consumers to identify community and program needs that BISAC could potentially address. These efforts resulted in the identification of needs across five broad domains:

- marketing, for example, the need for new program brochures and other initiatives to improve community understanding of BISAC;
- improving service quality, for example, the need for increased progress monitoring capacity and improved cohesion across geographically separate programs;
- staff in-service training, for example, the need for a new employee training protocol;
- networking with additional community agencies to foster alliances; and
- service expansion, for example, the need for additional vocational-, parenting-, and culture-focused services.

Following these information-gathering sessions, the executive leadership team met to consider the appropriateness, feasibility, and implementation cost of various initiatives. Ultimately, the team developed improvement of care plans related to program evaluation, data management, and program enhancement, which were launched three months later (for timeline, see Figure 1).

*Figure 1.* Timeline of Events.

	Jan 2012	Jun 2012	Jan 2013	Jun 2013	Jan 2014	Jun 2014	Jan 2015	Jun 2015	Jan 2016	Jun 2016	Jan 2017
Needs Assessment	New CEO begins; assesses organizational needs based on interviews with staff, clients, and community										
Community Outreach	Major community events ("Summer Jam" and "Strong Man") are launched and maintained										
	Smaller community fairs are launched and maintained										
Branding	BISAC rebranding initiative undertaken in collaboration with outside agency										
	BISAC transitions to in-house management of branding efforts										
Supervision and Training	Structured supervision and training models are developed, implemented, and continuously tracked										
Research	Research collaboration is begun with University of Hawai'i Psychology department.										
	Results of BISAC data projects are presented at local and national conferences										

### **3.0 Program Evaluation–Data Management Improvements**

#### ***3.1 Research Partnerships***

Although BISAC was one of the primary behavioral health providers in the rural areas of Hawai'i island and staff anecdotally observed client success, the organization had not conducted meaningful quantitative analyses to demonstrate the effectiveness of its programs. Leadership and staff were interested in examining client outcomes and predictors of successful discharge in order to better serve clients, meet the growing demands from funding organizations necessitating such data, and provide recommendations for improvement in overall delivery of services. They also aimed to gain greater recognition as a leading behavioral health provider on Hawai'i island, and hoped to obtain increased grant support. Thus, the executive leadership team contacted a local university professor, who was known within the community for his skills in program evaluation.

In 2014, BISAC began negotiations with the university professor, allocating 0.33% of the BISAC budget for basic program evaluation services. The professor and a psychology postdoctoral fellow began monthly meetings with the chief executive officer and information technology administrator to identify research questions and discuss the structure of the electronic health records system. Initial evaluation projects examined the client demographic, systematic, and programmatic variables predicting attendance at initial intake appointments and successful client discharge. For example, it was found that fewer days between the first referral phone call and first scheduled intake assessment predicted actual attendance at a first scheduled intake assessment (Orimoto, Vincent, Nakamura, Schwiter, & Preston-Pita, 2015). These and other findings resulting from ongoing program evaluation have gone on to be presented by the BISAC–university team at several local and national research conferences. The university–BISAC collaboration also resulted in the implementation of an online client outcome-monitoring tool and the exploration of potential screening instruments to identify comorbid conditions in clients presenting with substance abuse challenges.

#### ***3.2 Information Technology Advances***

Until August 2008, BISAC was functioning largely with paper health records and primitive clinical billing systems. This was especially problematic given difficulties related to geographic isolation of rural residents. For example, consumers requiring in-home visits often endured especially long waits for services, which included not only long commute times for service providers but additional delays due to the delivery, completion, and processing of hard copy paperwork. In order to comport with national trends, meet health care standards, and streamline policies and procedures for therapists traveling to all parts of the island, the executive leadership team sought to invest in updates to data management systems, hardware support, internal and external reporting, evaluation, and telecommunications. They believed that in order to realize gains from the use of their quality improvement resources, their systems required adequate infrastructure to deliver the care that the reporting tools supported (Patel, Butler, & Wells, 2006). Updates to information technology became a high priority, and were allocated approximately 4% of the organization budget.

It is important to note a number of key technological advances that occurred prior to the time period described here. In the summer of 2007, BISAC obtained and developed a platform for online employee training and data reporting (i.e., Sharepoint). This platform allowed for documentation of clinical supervision meetings, quality assurance surveys, employee surveys, and workflows. The following year, BISAC obtained and implemented an electronic health records system (ClaimTrak) that provided local hosting, technical support during Hawai‘i business hours, and the ability to build BISAC- and insurance-specific forms and processes. The system was allocated approximately 1% of the total budget and served as the primary clinical billing system while also tracking (a) referrals, (b) records, (c) outcome data, (d) document management, (e) consents, (f) urinalysis results, (g) medications, (h) census, (i) length of stay, (j) guarantor and authorization forms, and (k) electronic signatures. Further, in May 2009, BISAC leveraged its role as one of the largest clients of the primary local telecommunications provider to advocate for additional internet connectivity in an underserved region of the island in which its headquarters were located. BISAC leadership capitalized on personal connections with staff from the telecommunications firm, who in turn facilitated meetings between their executive team and BISAC’s. The firm ultimately agreed to expand services, running additional fiber optic cables to the BISAC facility, as well as to a large medical center and several community businesses that were located nearby. An emphasis on such organizational partnerships as linchpins for the advancement of mental health initiatives in rural communities has been repeatedly noted in the research literature (e.g., Glisson & Schoenwald, 2005; Molgaard, 1997).

While the aforementioned foundational work to enhance BISAC’s information technology capabilities occurred prior to the 2012–2017 study period, several notable efforts were made to capitalize on this technological framework in this five-year span. Beginning in 2012, electronic signature pads were implemented across all client services. This improved operations in at least three major ways: (a) drastically reducing the amount of time of various client service procedures, for example, medication order fulfillment; (b) allowing for immediate progress monitoring across all BISAC sites, as supervisors in the central office could read records of client interactions directly after they were completed; and (c) significantly improving quality control by eliminating many of the errors and delays inherent in the paper records system. Also, within the five-year study period the leadership team began to utilize data as a vehicle for the improvement of service delivery and the allocation of limited financial resources, the latter being a frequently noted challenge in rural mental health research (e.g., Bird et al., 2001; Brenes et al., 2015). More specifically, the newly-modernized technological infrastructure was not only used as a medical record system, but data from the system were extracted, evaluated frequently—in some cases on a daily basis—and used to identify service gaps and discern patterns in outcomes. For example, service records—including service type and hours of treatment—were pulled daily to monitor clients’ length of stay in a given service type, and to transition clients out of more intensive placements when warranted to create space for new clients. Data were also periodically pulled to explore various progress monitoring and treatment outcome-related questions. In addition to the aforementioned study linking the speed of intake assessment scheduling to the probability of intake assessment attendance (Orimoto et al., 2015), other analyses indicated that the likelihood of successful discharge from BISAC services increased significantly for clients placed in a therapeutic living program—compared to those who only received intensive outpatient services (Orimoto,

Nakamura, Schwiter, Milette-Winfrey, & Preston-Pita, 2017)— as well as for clients who attended sessions more frequently and scored lower on a measure of addiction severity (Orimoto, Nakamura, Schwiter, & Preston-Pita, 2016). Such findings have been used to guide service selection decisions and to inform policies and procedures that emphasize quick response times and promote treatment session attendance. Notably, the three studies cited here were facilitated through BISAC’s research university partnership; to increase the sustainability of these efforts beyond this partnership, BISAC also created a dedicated quality assurance manager position in 2012. Among other duties, this manager is responsible for regularly communicating program quality via annual reports to stakeholders and staff.

## **4.0 Program Enhancements**

### ***4.1 Standardization of Supervision and Staff Training Protocols***

During the initial needs assessment, BISAC employees indicated a desire for more supportive supervision. Prior to 2013, supervision occurred sporadically, was not documented, and lacked clear guidelines. Some staff members rarely received supervision and were thus understandably upset when they received negative feedback on performance evaluations. At the end of 2012, executive leadership prioritized the creation of standardized supervision protocols and greater provision of in-service training to staff, with the belief that these efforts would improve overall quality of care. Returning to Proctor et al.’s (2011) implementation outcomes, the major identified themes for improvement in these domains centered around adoption (initial implementation of new supervision and training protocols), fidelity (i.e., ensuring that supervision and training occurred at a high standard), and penetration (i.e., maximizing consistency of supervision and training across all providers and all locations).

Enhancements to the supervision model were informed in part by the Center for Substance Abuse Treatment’s research on supervision best practices (Center for Substance Abuse Treatment, 2009), and focused on increasing both frequency and quality of supervision. To these ends, BISAC’s leadership team created a new supervision manual in 2013 that clearly defined a supervisor’s role and expectations. As a result of extensive training efforts on this new manual (noted below), by 2017, each program’s supervision ranged from once per week to once per month and was contingent on degree and/or certification of the supervisee. Clinical supervision served as a collaboration between supervisor and supervisee to provide clinical guidance, ensure compliance with a quality assurance plan, and ensure that standards were well maintained. Supervision sessions with clinicians could include case consultation, review of progress towards professional goals, strengths and weaknesses, and recommendations from the supervisor. The supervisor typically (a) evaluated effectiveness of staff service, (b) assisted and provided guidance to staff in ensuring that service was in accordance with agency standards, (c) assisted the counselor in developing further skills in providing effective service, (d) monitored consultants to assure efficacy of program services, and (e) documented supervision notes and sent them to the Director of Human Resources. To increase adoption of this model, supervisor duties were tailored such that their direct service responsibilities were eliminated—except in emergency coverage situations—giving them sufficient time in their day to attend to their new roles. Standardized documentation forms were used as a framework for all supervisions and served to track employee needs, goals, and performance. For example, supervisors were



required to regularly complete a ‘supervision development plan’ for clinical staff under their care, and to share it with both supervisees and their clinical lead. This process helped to ensure fidelity to the supervision model and created accountability to promote sustained use.

To support supervision and staff needs and meet accreditation agreements, BISAC also increased training opportunities on a variety of topic areas. Training areas were derived from the popular Twelve Core Functions model originally proposed by Herdman (2005), and included (a) basic skills (needs assessment, admitting new clients, writing progress notes), (b) intervention techniques (motivational interviewing, collaborative documentation, active listening), (c) crisis management, (d) cultural sensitivity, (e) supervision (related to the new supervisor policies and procedures noted above) and other topics. Prior to 2012, training occurred primarily at monthly staff meetings. Following the routinization of supervision and training in 2013, staff members began receiving annual e-learning opportunities as well as program-specific, quarterly, and staff-wide trainings. This amounted to approximately twelve trainings per year per staff member.

#### ***4.2 Grassroots Marketing and Rebranding***

An ongoing challenge of increasing access to behavioral health in rural areas is heightening community awareness of service availability. One method of addressing this issue is to engage in outreach efforts aimed at increasing access to and initiation of treatment services. Interventions of this type can include renewed community awareness and screening programs, new means for financing mental health services, and expansion of treatment resources for underserved areas (Wang et al., 2005). In an effort to educate the public on services and improve BISAC’s overall reputation in the community, the executive leadership sought to rebrand and restructure the organization in 2012. They contracted a branding company for approximately two years (2012–2014) and created a new mission statement (‘Inspiring change, reclaiming lives’) and organizational values (‘INSPIRE: integrity, nurture, perseverance, innovation, respect, empowerment, success’). From these stated values, they developed a fresh logo and redesigned the website and brochures to both capture the vision and highlight good works of the agency. They also developed public service announcements that were aired during donated radio time and published articles in the local newspapers.

Following the well-established notion that positive relationships with key local stakeholders are necessary for effective service implementation in rural areas (e.g., Glisson & Schoenwald, 2005), staff and executive leadership members placed a heavy focus on further increasing the organization’s presence and visibility in community groups. First, executive leadership members joined four local coalitions promoting values consistent with the organization: (a) a homelessness coalition, (b) a coalition for pregnant women at risk for health problems and childbirth complications, (c) the mayor’s task force on homelessness, and (d) a coalition assisting criminal offenders in reintegrating with society after incarceration. Such memberships generally increased networking opportunities with other community service provider agencies that assisted many of BISAC’s clients, while also generating additional client referrals, increasing marketing opportunities, and increasing visibility in the community. Next, BISAC began sponsoring community events to celebrate resilience, wellness and recovery. Organizers selected venues with the goals of making the largest impact with stakeholders and lawmakers while

also building relationships within smaller, underserved communities. Related to the former goal, BISAC began holding a community fair (Summer Jam) and a strong man competition (Strong Man) in summer and fall 2012 in the largest town on the island. Related to the latter goal, in 2014, organizers also began planning and hosting two smaller community fun fairs per year in more rural areas, partnering with other health-related organizations that focused on local communities' needs. An important consideration across these and other marketing efforts was the reduction of stigma related to mental illness and substance abuse, which is often prevalent in rural communities (Komiti et al., 2006; Oliveira et al., 2006). The primary focus of the aforementioned community events was not on pathology, but on celebrating community—with efforts to make the education of participants on BISAC programming as unobtrusive as possible—and radio public service announcements noted above told success stories of BISAC program participants in order to humanize them and downplay stereotypes. Anecdotally, residents appeared grateful for BISAC's efforts to serve their communities, with one boy sharing the sentiment that the family fun fair was "the best day of [his] life." More objectively, attendance at Summer Jam events has consistently fallen between 3,000 and 4,000 local area residents. To prioritize community outreach financially, 1.03% of the total budget was allocated to support efforts, and this funding has been consistently renewed since that initial allocation to ensure sustainability of these events.

### **4.3 Culturally Competent Programming.**

Research has identified the role of cultural integration in health services in order to increase the acceptability of services to clients (e.g., Griner & Smith, 2006). Efforts toward cultural integration—health care that meets the social, cultural and linguistic needs of patients—could be enhanced by incorporating both traditional and contemporary knowledge and practices into patient care (Gureje et al., 2015). In Hawai'i, providers who understand and respect cultural factors (i.e., communication, expression of symptoms, coping styles and willingness to seek treatment) are thought to be better equipped to provide care that is respectful and responsive to local patients' beliefs and values (Office of Hawaiian Affairs, 2015). Though the need for cultural competence has always been a value of BISAC, executive leadership sought to fully integrate it into treatment procedures for clients. Thus, two programs addressing clients' post-treatment needs (e.g., self-efficacy, maintaining abstinence, preparedness for entering the workforce) were selected to formally include discussion of cultural identity and values and connection to the land, in accordance with the implementation outcome of appropriateness.

While BISAC had a comprehensive set of treatment programs, executive leadership members noted that clients struggled to achieve self-sufficiency due to lack of support in basic employment skills. A vocational training program, Po'okela (meaning 'champion' in Hawaiian), was designed to fill this need and was embedded within BISAC's residential 'therapeutic living' program in October 2013. The clinical leadership sourced material from three locally-utilized vocational programs: Ka Lā Hiki Ola (Say, R., n.d.), Career Cruising (Career Cruising, n.d.), and Coaching Young People for Success (CYPFS, n.d.). The final product was a manualized curriculum, rooted in Hawaiian values, proverbs, and myth. As of August 2016, 176 men and 43 women had completed the program. While quantitative analyses of program outcomes were unavailable at the time of this writing, one client provided the following feedback for the program: "I have a chance again at having a good successful life because of the job training opportunities through Po'okela."

Hawaiian culture places a strong emphasis on connection to earth and land, and as such, BISAC decided to utilize a donated three-acre plot of land for a therapeutic gardening program entitled Hānai ‘aina (‘nourishing lands’ in Hawaiian). Beginning in 2015, clients were instructed and supervised by a Native Hawaiian cultural expert to work in the garden and/or prepare food on a bimonthly basis. The accompanying lessons encouraged a personal accounting of substance use and how the cultural meaning of the land as well as the practices necessary for the care of the land were necessary for and congruent with healthy, caring, non-violent relationships in families and communities. Research suggests that cultural interventions such as this program are linked to statistically higher personal recovery and treatment compliance and lower incidence of aggression (Isaacs, 2008). While outcome data are forthcoming, clients have anecdotally described the positive effect that the program has had on their recovery. One client shared that “in [his/her] addiction [he/she] felt dirty and kept all of [his/her] emotions and traumas inside...Being in treatment and reconnecting with the land made [him/her] cleanse and release everything that was holding [him/her] back.”

## **5.0 Lessons Learned**

Naturally, the implementation of multifaceted and multi-year quality improvements interventions has highlighted several broad themes with regard to lessons learned. It is hoped that the following reflections might serve as discussion points for providers considering the adoption of similar efforts.

### **5.1 Utilize Data to Inform Decisions**

Within the context of widespread improvement innovations, BISAC utilized qualitative and quantitative data collection and interpretation to inform efforts at the organizational, client, and therapist levels. Consistent with the implementation outcomes of appropriateness and acceptability, prior to selecting which improvement projects to pursue, BISAC leadership met with each staff member individually to gather thoughts on the perceived needs of the organization. Leadership also began participating in community forums and coalitions to obtain outsider perspectives of BISAC and the services needed in the community. Finally, leadership examined consumer satisfaction surveys and reflected on concerns from clients, including clients’ desires for a ‘one-stop shop’ for substance use treatment, vocational training, and ongoing mental health services. The leadership then conducted management meetings to examine themes in these barriers and gaps in services. Information gleaned from these efforts served as a guidepost for how to best prioritize the needed infrastructure and resource improvements.

With a renewed prioritization of quality improvement—and in pursuit of the implementation outcome of fidelity—BISAC needed more effective methods for tracking the effectiveness of its efforts on clinical processes and outcomes. The implementation of an electronic health records system offered increased opportunities for more complex data evaluation and subsequent enhancement of clinical processes. Through the research partnership with the local university, BISAC leadership utilized demographic and service data (i.e., date of initial phone referral, date of intake assessment) to identify predictors of attendance at a first intake assessment appointment. As mentioned above, results from this evaluation revealed that a decrease in days between the first referral phone call and the first scheduled intake assessment increased the likelihood of attendance at that

assessment (Orimoto et al., 2015). In order to better support clients at risk for early drop out, BISAC leadership consequently adjusted procedures, decreasing the amount of time between initial referral phone calls and intake appointments and offering same-day assessments. In order to track clinical progress at the organizational level, BISAC also began to utilize the electronic health record platform to collect session-by-session data on current clients. In the near future, such information will be shared with clients regularly and will be utilized to better assess treatment progress. Electronically-collected clinical data will also be used to assess efficacy of the aforementioned vocational program and therapeutic garden initiatives. Finally, at the staff level, therapists and supervisors collected qualitative data on therapists' training goals. This documentation informed supervisors' abilities to offer targeted support to clinic staff.

### **5.2 Invest in Staff Buy-in**

The advent of the numerous and simultaneous improvement efforts at BISAC naturally led staff and stakeholders to be wary of the time and resources necessary to accomplish new tasks (i.e., implementation cost, as described by Proctor et al., 2011). Administration subsequently invested a significant amount of time in repeatedly explaining the importance of changes and identifying barriers. As an example, supervisors were logically concerned about the additional time required to meet the new expectations of the supervision policies and procedures. BISAC leadership thus discussed the ways that more structured supervision could improve clinical service—a key value of the organization—provide guidance to staff on improving performance measures, and help staff gain more learning opportunities on substance abuse counseling core functions (e.g. assessments, screening, intervention, etc.). To attend to staff concerns, leadership then offered staff opportunities for decreased workload during adjustment to new procedures and additional staff were cross-trained to help provide continual support.

Similarly, the chief executive officer initially met opposition to her request for rebranding the values and logo of the organization in 2012, with staff questioning the necessity for the associated expenses. She worked to repeatedly expose staff and stakeholders to her reasoning for the rebranding and the vision to address gaps in service and improve overall quality of care for clients. Buy-in appeared to increase after staff and stakeholders began witnessing results of marketing and outreach efforts (e.g., changing of mission statement, vision, and values; updated website and brochures).

### **5.3 Invest Time and Resources at the Outset**

Rural mental health service providers, like many nonprofit social service agencies, are often and understandably thrifty. While such a philosophy is judicious in most situations, quality improvement efforts might initially call for higher cost investments to obtain higher quality products with longer lasting benefits, necessitating a balance between implementation outcomes of cost and sustainability. As an example, when selecting an electronic health records system, BISAC leadership wanted to ensure that the system met all criteria necessary to allow for optimal clinical utility and data collection. This 'wish list' was developed with the logic that ineffective data collection and recording processes would impede interpretation, publication, and dissemination of improvement work (Goldmann, 2011). While several of the potential options met most conditions, only one product

had all of the qualities that BISAC valued. Though this system was more expensive than the other options, BISAC chose it to avoid having to convert to a more manageable system in the foreseeable future. After more than a decade, BISAC clinical documentation has been effectively maintained through the original electronic health records system.

Similarly, BISAC chose to invest in the developmental costs associated with upgrading to an electronic health records system. Prior to 2009, Hawai‘i island had limited internet coverage. In addition to aforementioned advocacy with internet providers to run more expansive fiber optic cables throughout the island, BISAC purchased data cards for staff members to ensure that staff were not burdened by delays in accessing the online system. While these efforts were costly and time-consuming at the outset, they ensured effective implementation and utilization of the electronic health records system.

Unfortunately, one missed opportunity for investment at the outset of these initiatives relates to careful a priori planning and building of a system for monitoring the progress and outcomes of these many organizational improvement efforts. While some information related to implementation outcomes is obvious or easily-inferred (e.g., the occurrence of community outreach events like Summer Jam or the continued adherence to quality assurance procedures as described in annual reports), there are still a number of gaps in the understanding of staff and consumer perceptions and behaviors related to these new initiatives. In hindsight—and as a recommendation for other similar organizations—BISAC would have benefited from building into regular procedures relevant surveys (e.g., related to staff satisfaction and compliance with the new supervision and training model or to consumer impressions of new treatment programs), performance metrics (e.g., logging of frequency and content of supervision meetings), or other means of measuring progress over time. While a review of the research on such progress and outcome monitoring initiatives in mental health organizations is beyond the scope of this paper, several references are provided to interested readers. Respectively, they offer a number of considerations for (a) monitoring the implementation of evidence-based practices in a mental health system (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009); (b) engaging mental health users in quality assurance efforts (Weinstein, 2006); and (c) understanding staff behavior patterns in the implementation of progress monitoring measures in a local mental health system (Milette-Winfrey, Nakamura, Kotte, & Higa-McMillan, 2019).

#### ***5.4 Be a Student, Rather Than a Teacher***

Much has been written about the importance of collaborating with rural communities to develop effective mental health services (e.g., Glisson & Schoenwald, 2005; Heflinger & Cristens, 2006). However, the process for achieving shared collaboration is less frequently reported. BISAC staff have partnered with small, rural communities across multiple improvement efforts, particularly with regard to grass roots marketing and culturally competent programming. Through the development of those efforts, BISAC staff have witnessed first-hand the importance of maintaining humility, patience, and respect when joining with the local communities.

Prior to approaching town leadership or communities about developing programs or services, staff typically conduct exploratory research on the culture of the community and its key stakeholders. In Hawai‘i island communities, BISAC staff

discovered that it was vital to have a positive initial interaction with the respected kūpuna (elders) of a given region. Positive interactions primarily involved listening to the elders without much talking and trusting that listening would uncover the necessary answers to questions. Without approval from the kūpuna, community involvement was nearly impossible. BISAC staff have also learned that they must follow through on promises to community members or risk their access to the community. For instance, BISAC committed to hosting a community event by asking for permission, collaborating with community members and encouraging participation, and ensuring that the event was organized and successfully implemented.

### ***5.5 Preserve Gains to Avoid the Need to Rebuild***

While BISAC leadership staff have learned to recognize the importance of investing time and resources at the initiation of quality improvement efforts, they have also come to value investment in maintaining programs (i.e., sustainability as termed by Proctor et al., 2011). In the natural evolution of initiatives, it is tempting for organizations to spend increasingly less energy on the maintenance of quality improvement efforts. However, without ongoing work to uphold improvements, the organization might spend even more time rebuilding the same initiatives in the future. Following the two-year collaboration with a contractor to rebrand BISAC, the BISAC chief executive officer assumed the role of maintaining branding and marketing for the organization. Though the branding agency collaborated with BISAC to develop logos, mission statements, basic pamphlets and the website, ongoing efforts were needed to maintain management of all social media accounts, merchandising, and event planning. While the chief executive officer reported this effort as time-consuming, she also endorsed the belief that working to maintain the BISAC reputation was more effective in the long term than needing to reestablish it.

Similar logic applies to maintaining training gains. Upon implementation of various technological improvements (e.g., electronic health records, training platforms), BISAC staff were trained in basic use of the programs. However, many staff members had limited technical abilities and struggled to utilize the software. BISAC leadership thus implemented more ongoing training opportunities, involving a high degree of hands-on training and peer pairing with key supporters, with a heavy focus on ongoing maintenance of staff skills in order to maintain initial training gains.

## **6.0 Final Thoughts**

This review offers a five-year narrative of the multifaceted quality improvement efforts and associated lessons learned from a midsize, rural, substance abuse treatment program. While much has been accomplished within a short amount of time, organizational changes were slow to start and have required effort to maintain gains. BISAC's evolution offers an example of how to practically implement innovative efforts in a period of transition. The authors are grateful to the many individuals who have contributed to the development and maintenance of the efforts described here.

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